

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/06/2012
NAME OF PROVIDER OR SUPPLIER  BRAKEBILL NURSING HOME INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>Amended Statement of Deficiencies.</p> <p>Investigation of complaint #29335, #29393, and #29340 was conducted at Brakebill Nursing Home, on February 23, 2012 through March 6, 2012. No deficient practices were cited for complaint #29335 or #29393. Deficient practices were cited for complaint #29340. Based on investigation of complaint #29340, the facility was cited at Immediate Jeopardy.</p> <p>A partial extended survey was conducted on March 6, 2012.</p> <p>The Administrator, Director of Nursing, and Unit Manager were informed of the Immediate Jeopardy in the office of the Administrator on March 5, 2012, at 2:15 p.m.</p> <p>The Immediate Jeopardy was effective from January 16, 2012 until March 2, 2012. Substandard Quality of Care was cited under F223, F226 and F309. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received on March 6, 2012 and corrective actions were validated as having been corrected by March 2, 2012 during on-site conducted March 6, 2012.</p> <p>The non-compliance of the Immediate Jeopardy tags continue at a scope and severity of a "D" level for Quality Assurance by monitoring of corrective actions.</p>	F 000	<p>3/27/12 POC #4 acceptable</p>		
F 223	483.13(b), 483.13(b)(1)(i) FREE FROM	F 223			3/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<u>Norma E Kinsey</u>	<u>Administrator</u>	<u>3/22/12</u>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223 SS=J	<p>Continued From page 1</p> <p><b>ABUSE/INVOLUNTARY SECLUSION</b></p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of literature on pacemaker devices, review of facility documents, and interview, the facility failed to ensure one resident (#5) of sixteen residents reviewed was protected from abuse.</p> <p>The facility's failure caused or was likely to cause serious harm, injury, impairment, or death to resident #5 as a result of Licensed Practical Nurse (LPN) #1 placing a magnet on the chest of resident #5 who had an implanted cardiac pacemaker while resident #5 was alive. The placing of the magnet could inhibit the pacemaker from functioning increasing the likelihood of death for resident #5.</p> <p>The Administrator, Director of Nursing, and Unit Manager were informed of the Immediate Jeopardy in the office of the Administrator on March 5, 2012, at 2:15 p.m.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on</p>	F 223	<p><b>F223 SS=J</b></p> <p>What corrective action will be accomplished for the resident found to have been affected by the deficient practice that facility failed to ensure that resident #5 was not protected from abuse?</p> <p>Unable to do immediate corrective action as resident had expired on 10/27/11 Terminal diagnosis.</p> <p>How the facility will identify other residents having the potential to be affected by the deficient practice that resident was not protected from abuse?</p> <p>All current residents with a pacemaker were identified by the DON and Quality Nurse and charts were reviewed for type of pacemaker and frequency of required checks completed on 2/29/12. A policy and procedure for pacemaker checks was developed on 2/29/12 by the Quality Nurse, Medical Director and input from the Telerhythmics representative (attached policy/procedure). Staff was educated on this policy and procedure on 3/13/12.</p> <p>What measures will be put in place to ensure that the deficient practice does not recur?</p> <p>All pacemaker check boxes will be locked and secured in the unit mediation cabinet. The DON and the two unit managers will maintain possession of the key to this room at all times. Patients scheduled pacemaker checks are performed on day shift Monday through Friday only. The Nurse performing will notify the DON or Unit Managers to obtain pacemakers check device and sign out on pacemaker log.</p>		3/13/12

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F 223

Continued From page 2

January 17, 2011 with diagnoses to include Cardiac Dysrhythmia with Pacemaker Implant, Atrial Fibrillation, Chronic Anticoagulant Therapy, Hypertension, Hyperlipidemia, Anemia, Chronic Obstructive Pulmonary Disease, Depression, and Chronic Pain.

Medical record review of the Minimum Data Set, dated October 14, 2011, revealed the resident was rarely able to understand others; was sometimes able to make self understood; had short and long term memory deficits; had severely impaired decision making skills; required two person assistance for bed mobility and transfers; was non-ambulatory; required two person assistance for all activities of daily living; and was incontinent of bowel and bladder.

Medical record review of the results from the cardiac pacemaker monitoring company, dated May 26, 2011 and August 25, 2011, revealed "...Pacemaker: Medtronic, Inc. VERSA VEDR01 (specific type of device implanted)...Implant date: February 5, 2010...Diagnosis: SSS (Sick Sinus Syndrome - a malfunction of the heart's primary pacemaker causing an abnormal heart rhythm)..."

Medical record review of the recapitulation Physician Orders, dated October 1 - 31, 2011, revealed the resident was initially ordered to be a "DNR" (Do Not Resuscitate) on January 17, 2011 and the order was to be continued.

Medical record review of the Medication Administration Record, dated October 1 - 31, 2011, revealed the resident was identified as DNR status.

F 223

The validation of a physician order for pacemaker checks will be done before check procedure and documented on the log by the DON and/or unit managers to return and secure pacemaker check box. This process was implemented on 3/13/12. All dayshift licensed nurses and unit coordinators will be trained regarding pacemaker check skills by the DON and DON will verify all staff for competency as pacemakers check are done. As orders for frequency of pacemakers checks are usually ordered on a 3-6 month basis by the Physicians from 3/12/12 to this date, there have been no scheduled pacemaker checks. The DON has a master list of all residents who require pacemaker checks with scheduled dates. Unit managers will be trained on pacemaker checks by the DON on the next scheduled resident pacemaker check date. The DON was validated competent in this skill and education regarding the revised pacemaker policy by the Medical Director, Dr. Pearman on 3/12/12. The Director of nursing inserviced the Unity Managers on the new policy and procedure for pacemaker checks on 3/12/12. All staff training regarding pacemaker check skills and policy were completed 3/13/12. All new licensed hires will have training by the DON prior to performing checks evidenced by competency skills check list. The DON and Unit Managers will maintain a master list of all trained licensed staff and update as needed with any new hires. A licensed nurse who is not identified on the master list will not be allowed to perform this skill. Training for these individuals will be scheduled with date of resident's next scheduled pacemaker check. Pacemaker check log will also include verification of the physician order by DON and licensed staff member.

3/13/12

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F 223	<p>Continued From page 3</p> <p>Medical record review of the Physician's Order, dated October 18, 2011, no time noted, revealed "...have POA (Power of Attorney) sign Advance Directive (POST - Physician's Order for Scope of Treatment) for CMO (Comfort Measures Only)..."</p> <p>Medical record review of the Physician's Order, dated October 19, 2011, no time noted, revealed "...Make pt (patient) CMO DNR...no labs, no x-rays, no IV's (intravenous fluids), no antibiotics, no TF (tube feeding)..."</p> <p>Medical record review of the Clinical Record Nurse's Notes revealed the following sequential notes: October 22, 2011, at 2:30 a.m. - "...resting comfortable..."; October 23, 2011, at 4:00 a.m. - "...resting...periods of apnea (not breathing for brief periods)...comfortable..."; October 23, 2011, 3:00 p.m. to 11:00 p.m. (shift) - "...resting quietly...periods of apnea noted..."; October 24, 2011, at 2:30 a.m. - "...resting...periods of apnea noted..."; October 27, 2011, at 1:40 p.m. - "Resident c/ (with) no respirations or pulse. Pronounced death"; October 27, 2011, 7:00 a.m. to 3:00 p.m. (shift) - "Deactivated (questionable spelling) Pacemaker" signed by Licensed Practical Nurse (LPN) #1; October 27, 2011, at 2:00 p.m. - "(named) funeral home here to transport body to funeral home."</p> <p>Review of facility Incident Report for Resident #5, dated January 16, 2012, no time noted, signed by the Assistant Administrator, revealed "...CNA (Certified Nursing Assistant) #1 entered nursing office had several complaints about LPN #1. Questioning why a magnet was placed on Resident #5's chest on the day (resident #5) died...noted CNA #1 did not work on the day of</p>	F 223	<p>After pacemaker check completed the careplan will be updated to reflect date of pacemaker check. This will also be documented in the nurse's notes.</p> <p>How the corrective action will be monitored to ensure that deficient practice does not recur:</p> <p>The weekly log of pacemaker checks will be monitored by the DON on a weekly basis (every Friday) and reported to the QI Nurse weekly for 6 months. Any variance in data will be immediately investigated by the DON. This process was initiated 3/13/12. If compliance is 100% at the end of six months, logs will be checked monthly and reported to the QI Quarterly Times Four. The QI team consists of Medical Director, Administrator, Pharmacist, Unit Coordinator, MDS Coordinator, Rehab director, Activity director, Dietary Manager, Housekeeping and Maintenance Supervisors and Medical Records.</p>		3/13/12

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F 223	<p>Continued From page 4</p> <p>(resident #5's) death October 27, 2011...(CNA #1) discussed all complaints with (named) Administrator and (named) DON (Director of Nursing)..."</p> <p>Review of facility Incident Report for Resident #5, dated February 13, 2012, at 1:00 p.m., signed by the Director of Nursing, revealed " (named) TBI (Tennessee Bureau of Investigation) at facility...investigating the death of (resident #5). Requested (resident #5's) entire medical record and access to any staff requested. Request honored...Administrator present..."</p> <p>Interview by phone with CNA #2 on February 29, 2012, at 8:25 p.m., confirmed on October 27, 2011, around lunchtime, CNA #2 was cleaning resident #5 along with CNA #3 and #4 and observed "a doughnut shaped red plastic covered" device on the chest of resident #5. Continued interview confirmed the resident was alive and breathing at the time. Continued interview revealed CNA #2 asked LPN #1 what the device was and was told to "leave it alone". Continued interview confirmed the CNA had never seen the device before. Continued interview revealed the CNA was talking about the observation sometime around Christmas and was told by CNA #1 that the device was a magnet and was not to be used on a dying pacemaker patient. CNA #1 reported the incident to Administration on January 16, 2012.</p> <p>Interview by phone with CNA #3 on March 3, 2012, at 10:10 a.m., confirmed CNA #3 was helping clean resident #5 on October 27, 2011 and observed what looked like "a roll of red and white tape on the left side of the chest" of resident</p>	F 223		

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F 223	<p>Continued From page 5</p> <p>#5. Continued interview confirmed the resident was breathing at the time. Continued interview confirmed when LPN #1 was asked about the device the LPN told CNA #3 "It's a magnet. Leave it alone". Continued interview confirmed CNA #3 stated sometime around Christmas 2011 CNA #1 overheard CNA #3 talking about the incident and told CNA #3 a magnet was not to be used with a pacemaker.</p> <p>Interview by phone with CNA #4 on March 3, 2012, at 10:40 a.m., confirmed CNA #4 was helping clean resident #5 on October 27, 2011, around 10:00 a.m., and observed what "looked like a rolled up white tape on the left side of the chest" of resident #5. Continued interview revealed the resident was breathing. Continued interview confirmed the device was in contact with the skin of the resident and visible between the collarbone and breast area.</p> <p>Interview by phone with the Assistant Administrator on March 2, 2012, at 3:30 p.m., and review of an undated written statement, dated as received by the facility on March 7, 2012 and signed by the Assistant Administrator of January 16, 2012, regarding the Assistant Administrator presence for the events of January 16, 2012 and February 13, 2012, confirmed the Assistant Administrator was not informed of the exact nature of the incident reported on January 16, 2012; but was present while TBI interviewed LPN #1 on February 13, 2012. Continued interview revealed LPN #1 informed TBI about placing a magnet on resident #5's chest to deactivate the pacemaker when resident #5 was still living.</p> <p>Review of the facility policy Abuse Policy, dated</p>	F 223			

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September 25, 2002, revealed "...Residents must not be subjected to abuse by anyone...Abuse means willful infliction of injury..."

Review of literature on magnets and pacemakers by Medscape, dated May 9, 2011, revealed: "...Magnet Inhibition: In most devices, placing a magnet over a permanent pacemaker temporarily "reprograms" the pacer into asynchronous (to cease to cause to operate at the same rate) mode. It does not turn the pacemaker off. Each pacemaker type has a unique asynchronous rate for beginning-of-life (BOL), elective replacement indicator (ERI), and end-of-life (EOL). Therefore, if the device company parameters are known, application of a magnet can determine if the pacer's battery needs to be replaced. Further interrogation or manipulating of the device should be performed by an individual skilled in the technique ...Although many different branded pacemaker/ICD (internal cardiac defibrillator) magnets are available, emergency physicians should be aware that in general any pacemaker/ICD magnet can be used to inhibit the device..."

Interview in the Activity Therapy room with the Medical Director, who was the resident's attending physician, on February 29, 2012, at 11:30 a.m., revealed the Medical Director had no knowledge of the allegation of LPN #1 placing a magnet on the chest of resident #5 on October 27, 2011 until February 13, 2012 when the TBI completed a phone interview with the Medical Director. Continued interview confirmed no Physician's order was written to utilize a magnet on resident #5 for any reason other than pacemaker monitoring as directed by the

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F 223	<p>Continued From page 7</p> <p>company performing the readings on the specified dates by the company. Continued interview confirmed there was no reason for a magnet to be in the room or on the chest of any resident with a pacemaker.</p> <p>Interview on March 5, 2012, at 3:30 p.m., in the Administrator's office with the Administrator confirmed LPN #1 placed a magnet on the chest of resident #5 who had a pacemaker and was alive at the time the magnet was placed on the resident's chest on October 27, 2011.</p> <p>The Immediate Jeopardy was effective from January 16, 2012 through March 2, 2012. A written Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on March 6, 2012 and corrective actions were validated as having been completed on March 2, 2012 through review of the facility documents and staff interviews conducted on-site on March 6, 2012. The verification of the allegation of compliance was confirmed by:</p> <p>1.) Reviewing the facility's revised policy for Abuse Prevention/Reporting Investigation to include more comprehensive information related to identification, preventing occurrences, reporting, investigating, protecting, and procedures.</p> <p>2.) Reviewing the facility's new policy and inservice records for Pacemaker Checks procedure.</p> <p>3.) Reviewing the facility's new policy and inservice records for the new Pacemaker/Defibrillator procedure.</p>	F 223			

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F 223	Continued From page 8  4.) Conducted interviews with CNA's and LPN's on all units, Housekeeping staff on all units, and Activity staff to ensure all had received inservices on Abuse Prevention/Reporting investigation and were able to identify types of abuse and when and how to report. Reviewing of the facility's inservice records on abuse, dated March 1 -2, 2012, to ensure all staff were inserviced prior to returning to work. Review of the facility plan for staff to be inserviced on abuse prior to returning to work if staff had not attended the abuse inservices.  5.) Reviewed an additional six medical records for residents with pacemakers.  6.) Reviewed an additional six medical records for residents on Comfort Only Care.  7.) Reviewed an additional three medical records of incidents of suspected abuse reported since March 2, 2012 to ensure the facility was following the procedures for reporting and investigating.  Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a plan of correction.	F 223			
F 226 SS=J	C/O #29340 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226			3/15/12

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This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of literature of pacemaker devices, facility policy review, review of facility documents, and interview, the facility failed to ensure timely and completion of an allegation of abuse investigation; failed to immediately suspend the alleged perpetrator of abuse; and failed to notify the State in a timely manner of an allegation of abuse for one resident (#5) of sixteen residents reviewed.

The facility's failure caused or was likely to cause serious harm, injury, impairment or death to resident #5 as a result of the facility failure to ensure a timely and complete investigation of an allegation of abuse; failed to immediately suspend the alleged perpetrator of abuse; and failed to notify the State in a timely manner of an allegation of abuse for resident (#5).

The Administrator, Director of Nursing, and Unit Manager were informed of the Immediate Jeopardy in the office of the Administrator on March 5, 2012, at 2:15 p.m.

The findings included:

Resident #5 was admitted to the facility on January 17, 2011 with diagnoses to include Cardiac Dysrhythmia with Pacemaker Implant, Atrial Fibrillation, Chronic Anticoagulant Therapy, Hypertension, Hyperlipidemia, Anemia, Chronic Obstructive Pulmonary Disease, Depression, and Chronic Pain.

F 226

F-226 SS=J

What corrective action will be accomplished for the resident found to be affected by the deficient practice that facility failed to report, investigate and report in a timely manner of alleged abuse or report the alleged perpetrator or abuse and failed to notify state?

*Policy on resident abuse prevention/reporting investigating was revised on 2/29/12 and 3/1/12 by the Director of Nursing and Unit Managers. Any associate not present on above dates were provided one on one education prior to beginning scheduled work. A master list is maintained by the DON to insure all associates received this training. This process is on-going due to employee leaves etc. Associates are expected to inform their supervisor/administrator of any concern they have at any time without fear of reprisal. Education included the need to validate Physician order for any patient intervention.*

How the facility will identify other residents having the potential to be affected by the same deficient practice?

*All residents have the potential to be affected by the deficient practice. Revised policy of reporting, preventing and investigating abuse was developed on 2/29/12 by the Administrator and DON. All associates were in-serviced on 2/29/12 and 3/1/12 on all forms of abuse and encouraged to report any unusual events that he or she may feel uncertainty regarding without fear of reprisal. The revised policy requires immediate suspension on the alleged abuser and timely notification to the state of validated incident.*

3/12/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/06/2012
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NAME OF PROVIDER OR SUPPLIER

BRAKEBILL NURSING HOME INC.

STREET ADDRESS, CITY, STATE, ZIP CODE  
5837 LYONS VIEW PIKE  
KNOXVILLE, TN 37919

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 226 Continued From page 10

Medical record review of the Minimum Data Set, dated October 14, 2011, revealed the resident was rarely able to understand others; was sometimes able to make self understood; had short and long term memory deficits; had severely impaired decision making skills; required two person assistance for bed mobility and transfers; was non-ambulatory; required two person assistance for all activities of daily living; and was incontinent of bowel and bladder.

Medical record review of the results from the cardiac pacemaker monitoring company, dated May 26, 2011 and August 25, 2011, revealed "...Pacemaker: Medtronic, Inc. VERSA VEDR01 (specific type of device implanted)...Implant date: February 5, 2010...Diagnosis: SSS (Sick Sinus Syndrome - a malfunction of the heart's primary pacemaker causing an abnormal heart rhythm)..."

Medical record review of the recapitulation Physician Orders, dated October 1 - 31, 2011, revealed the resident was initially ordered to be a "DNR" (Do Not Resuscitate) on January 17, 2011 and the order was to be continued.

Medical record review of the Medication Administration Record, dated October 1 - 31, 2011, revealed the resident was identified as DNR status.

Medical record review of the Physician's Order, dated October 18, 2011, no time noted, revealed "...have POA (Power of Attorney) sign Advance Directive (POST - Physician's Order for Scope of Treatment) for CMO (Comfort Measures Only)..."

Medical record review of the Physician's Order,

F 226

*The DON reviews all incidents/alleged abuse immediately when notified and is available on weekends/holidays by phone. In times of her absence the Unit Manager will be designated to be available.*

What measures will be put into place to ensure that the deficient practice does not recur?

*Abuse in-services will be done quarterly as mandated education by the DON/or designee. Random staff interviews (25) regarding abuse will be done monthly by DON and Unit Managers to assure staff understanding effective 3/2/12 and on-going. Incident investigation tool on all alleged incident abuse will be complete by the DON and Unit Managers to determine need of reporting to State effective 3/12/12. This is to be done within 24 hours of incident occurrence (attached form). Weekend staff is to notify administrator/regarding occurrence that may need to be state reported. Chart audits are performed weekly to validate physician orders as to treatment plan. Variances are to be reported to the DON immediately for resolution by Policy. Sample size is 10% of active charts.*

3/12/12

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F 226 Continued From page 11  
dated October 19, 2011, no time noted, revealed  
"...Make pt (patient) CMO DNR...no labs, no  
x-rays, no IV's (intravenous fluids), no antibiotics,  
no TF (tube feeding)..."

Medical record review of the Clinical Record  
Nurse's Notes revealed the following sequential  
notes: October 22, 2011, at 2:30 a.m. - "...resting  
comfortable..."; October 23, 2011, at 4:00 a.m. -  
"...resting...periods of apnea (not breathing for  
brief periods)...comfortable..."; October 23, 2011,  
3:00 p.m. to 11:00 p.m. (shift) - "...resting  
quietly...periods of apnea noted..."; October 24,  
2011, at 2:30 a.m. - "...resting...periods of apnea  
noted..."; October 27, 2011, at 1:40 p.m. -  
"Resident c/ (with) no respirations or pulse.  
Pronounced death"; October 27, 2011, 7:00 a.m.  
to 3:00 p.m. (shift) - "Deactivated (questionable  
spelling) Pacemaker" signed by Licensed  
Practical Nurse (LPN) #1; October 27, 2011, at  
2:00 p.m. - "(named) funeral home here to  
transport body to funeral home."

Review of facility Incident Report for Resident #5,  
dated January 16, 2012, no time noted, signed by  
the Assistant Administrator, revealed "...CNA  
(Certified Nursing Assistant) #1 entered nursing  
office had several complaints about LPN #1.  
Questioning why a magnet was placed on  
Resident #5's chest on the day (resident #5)  
died...noted CNA #1 did not work on the day of  
(resident #5's) death October 27, 2011...(CNA  
#1) discussed all complaints with (named)  
Administrator and (named) DON (Director of  
Nursing)..."

Review of facility Incident Report for Resident #5,  
dated February 13, 2012, at 1:00 p.m., signed by

F 226

How the corrective action will be monitored to  
ensure that the deficient practice does not recur?

*Incident reports will be reviewed daily by the  
DON, Unit Coordinators and/or Administrator for  
appropriate follow-up action and as needed.  
Weekend incidents are called to the DON and/or  
Administrator as indicated in policy. The alleged  
abuser is immediately suspended from the facility  
(effective date 2/29/12). The monitoring of abuse  
or unusual incidents will be reported in QI  
Quarterly times Four, to identify trends, patterns  
or educational needs. This report will also include  
validation of Physician orders for any patients  
treatment. This will be reported quarterly times  
four and the thereafter bi-annually in QI. The QI  
committee consists of Medical Director,  
Administrator, Pharmacist, DON, Unit  
Coordinator, MDS Coordinator, Rehab Manager,  
Activity Director, Dietary Manager, Housekeeping,  
Maintenance Supervisors and Medical Records.*

3/12/12

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F 226	<p>Continued From page 12</p> <p>the Director of Nursing, revealed " (named) TBI (Tennessee Bureau of Investigation) at facility...investigating the death of (resident #5). Requested (resident #5's) entire medical record and access to any staff requested. Request honored...Administrator present..."</p> <p>Interview by phone with CNA #2 on February 29, 2012, at 8:25 p.m., confirmed on October 27, 2011, around lunchtime, CNA #2 was cleaning resident #5 along with CNA #3 and #4 and observed "a doughnut shaped red plastic covered" device on the chest of resident #5. Continued interview confirmed the resident was alive and breathing at the time. Continued interview revealed CNA #2 asked LPN #1 what the device was and was told to "leave it alone". Continued interview confirmed the CNA had never seen the device before. Continued interview revealed the CNA was talking about the observation sometime around Christmas and was told by CNA #1 that the device was a magnet and was not to be used on a dying pacemaker patient. CNA #1 reported the incident to Administration on January 16, 2012.</p> <p>Interview by phone with CNA #3 on March 3, 2012, at 10:10 a.m., confirmed CNA #3 was helping clean resident #5 on October 27, 2011 and observed what looked like "a roll of red and white tape on the left side of the chest" of resident #5. Continued interview confirmed the resident was breathing at the time. Continued interview confirmed when LPN #1 was asked about the device the LPN told CNA #3 "It's a magnet. Leave it alone". Continued interview confirmed CNA #3 stated sometime around Christmas 2011 CNA #1 overheard CNA #3 talking about the</p>	F 226			

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F 226	<p>Continued From page 13</p> <p>incident and told CNA #3 a magnet was not to be used with a pacemaker.</p> <p>Interview by phone with CNA #4 on March 3, 2012, at 10:40 a.m., confirmed CNA #4 was helping clean resident #5 on October 27, 2011, around 10:00 a.m., and observed what "looked like a rolled up white tape on the left side of the chest" of resident #5. Continued interview revealed the resident was breathing. Continued interview confirmed the device was in contact with the skin of the resident and visible between the collarbone and breast area.</p> <p>Interview by phone with the Assistant Administrator on March 2, 2012, at 3:30 p.m., and review of an undated written statement, dated as received by the facility on March 7, 2012 and signed by the Assistant Administrator of January 16, 2012, regarding the Assistant Administrator presence for the events of January 16, 2012 and February 13, 2012, confirmed the Assistant Administrator was not informed of the exact nature of the incident reported on January 13, 2012; but was present while TBI interviewed LPN #1 on February 13, 2012. Continued interview revealed LPN #1 informed to TBI about placing a magnet on resident #5's chest to deactivate the pacemaker when resident #5 was still living.</p> <p>Review of the facility policy Abuse Policy, dated September 25, 2002, revealed "...Residents must not be subjected to abuse by anyone...Abuse means willful infliction of injury...Policy is to develop and implement procedures to prevent abuse...components...training...investigation, protection, reporting...protect the resident and the</p>	F 226			

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F 226	<p>Continued From page 14</p> <p>complainant...immediately respond...report by phone to the State of Tennessee within twenty-four hours, followed by a written report within forty-eight hours..."</p> <p>Review of the facility policy Incident/Accident Documentation and investigating, dated June 29, 2005, revealed "...all resident incidents...immediately investigated...document on an incident report...Incident team:...meet daily to review all incidents/accidents..."</p> <p>Review of the facility policy Reporting Accident/Incidents, no date, Document all findings on an incident report...report to oncoming shifts (and) the resident's responsible party..."</p> <p>Interview in the Activity Therapy room with the Administrator on February 28, 2012, at 9:45 a.m., confirmed the policy did not contain the necessary information to ensure all the needed elements the facility staff were to follow. Continued interview confirmed the policy lacked directions to immediately suspend the accused until an investigation had been completed.</p> <p>Review of literature on magnets and pacemakers by Medscape, dated May 9, 2011, revealed: "...Magnet Inhibition: In most devices, placing a magnet over a permanent pacemaker temporarily "reprograms" the pacer into asynchronous (to cease to cause to operate at the same rate) mode. It does not turn the pacemaker off. Each pacemaker type has a unique asynchronous rate for beginning-of-life (BOL), elective replacement indicator (ERI), and end-of-life (EOL). Therefore, if the device company parameters are known, application of a magnet can determine if the</p>	F 226			

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F 226	<p>Continued From page 15</p> <p>pacers battery needs to be replaced. Further interrogation or manipulating of the device should be performed by an individual skilled in the technique ...Although many different branded pacemaker/ICD (internal cardiac defibrillator) magnets are available, emergency physicians should be aware that in general any pacemaker/ICD magnet can be used to inhibit the device..."</p> <p>Interview in the Activity Therapy room with the Medical Director, who was the resident's attending physician, on February 29, 2012, at 11:30 a.m., revealed the Medical Director had no knowledge of the allegation of LPN #1 placing a magnet on the chest of resident #5 on October 27, 2011 until February 13, 2012 when the TBI completed a phone interview with the Medical Director. Continued interview confirmed no Physician's order was written to utilize a magnet on resident #5 for any reason other than pacemaker monitoring as directed by the company performing the readings on the specified dates by the company. Continued interview confirmed there was no reason for a magnet to be in the room or on the chest of any resident with a pacemaker.</p> <p>Review of the facility Time and Attendance Record for LPN #1 for January 2012 through March 2012, revealed LPN #1 worked January 16 through February 28, 2012, without suspension, for a total of 26 days. Interview with the DON in the Activity Therapy room on March 5, 2012, at 10:10 a.m., confirmed LPN #1 was not immediately suspended on January 16, 2012 while the facility conducted an investigation into the allegation of abuse by LPN #1. Continued</p>	F 226		

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F 226	<p>Continued From page 16</p> <p>interview confirmed LPN #1 was not suspended until February 16, 2012. Review of the facility Time and Attendance Records for February 2012 revealed the LPN worked on February 24, 27, and 28, 2012 (for a total of 3 days). Continued interview confirmed LPN #1 was allowed to return to the facility on February 24 to work in the facility on non-resident care duties; LPN #1 was not terminated until February 28, 2012; and the facility had not completed it's investigation until March 1, 2012.</p> <p>Interview on March 5, 2012, at 3:30 p.m., in the Administrator's office with the Administrator confirmed the facility failed to immediately suspend the accused perpetrator; failed to complete a timely investigation of abuse that had been reported on January 16, 2012; failed to ensure a policy for pacemakers; and failed to report the allegation of abuse made on January 16, 2012 to the State.</p> <p>The Immediate Jeopardy was effective from January 16, 2012 through March 2, 2012. A written Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on March 6, 2012 and corrective actions were validated as having been completed on March 2, 2012 through review of the facility documents and staff interviews conducted on-site on March 6, 2012. The verification of the allegation of compliance was confirmed by:</p> <p>1.) Reviewing the facility's revised policy for Abuse Prevention/Reporting Investigation to include more comprehensive information related to identification, preventing occurrences, reporting, investigating, protecting, and</p>	F 226			

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F 226	<p>Continued From page 17 procedures.</p> <p>2.) Reviewing the facility's new policy and inservice records for Pacemaker Checks procedure.</p> <p>3.) Reviewing the facility's new policy and inservice records for the new Pacemaker/Defibrillator procedure.</p> <p>4.) Conducted interviews with CNA's and LPN's on all units, Housekeeping staff on all units, and Activity staff to ensure all had received inservices on Abuse Prevention/Reporting investigation and were able to identify types of abuse and when and how to report. Reviewing of the facility's inservice records on abuse, dated March 1 -2, 2012, to ensure all staff were inserviced prior to returning to work. Review of the facility plan for staff to be inserviced on abuse prior to returning to work if staff had not attended the abuse inservices.</p> <p>5.) Reviewed an additional six medical records for residents with pacemakers.</p> <p>6.) Reviewed an additional six medical records for residents on Comfort Only Care.</p> <p>7.) Reviewed an additional three medical records of incidents of suspected abuse reported since March 2, 2012 to ensure the facility was following the procedures for reporting and investigating.</p> <p>Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a plan of correction.</p>	F 226			

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F 226	Continued From page 18	F 226			
F 309	C/O #29340	F 309			
SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F309=SSJ		3-12-12	
	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of literature on pacemaker devices, review of facility documents, and interview, the facility failed to ensure a staff member followed physician orders for services rendered. A Licensed Practical Nurse (LPN) placed a magnet on the chest of one resident (#5), who had an implanted cardiac pacemaker.</p> <p>The facility's failure to ensure staff adhered to physician orders caused or was likely to cause serious harm, injury, impairment, or death to one resident (#5) of sixteen residents reviewed.</p> <p>The Administrator, Director of Nursing, and Unit Manager were informed of the Immediate Jeopardy in the office of the Administrator on March 5, 2012, at 2:15 p.m.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on January 17, 2011 with diagnoses to include</p>		<p>What corrective action will be accomplished for those resident's found to be affected by the deficient practice that facility failed to ensure staff adhered to physician orders, caused or was likely to cause serious harm injury, impairment or death to resident # (5)?</p> <p><i>No immediate correction could not be done as patient expired on 10/27/11with Terminal diagnosis.</i></p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice; and what corrective action will be taken?</p> <p><i>All resident's have potential to be affected. The facility has a process by which all physician orders are verified by the practicing nurse prior to any patient treatment/intervention. A 24-hour chart check is done daily, by the 11-7 nurses on all orders written in the previous 24-hour period. Inservice regarding verification of a physician order for any patient procedure/treatment was provide to all licensed staff in concert with abuse training by the DON, Unit Managers on 2/29/12 thru 3/2/12. Nurse auditor/QI Nurse will audit 10% of active charts weekly for compliance of physician orders with treatment plan.</i></p>		

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PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

445114

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY  
COMPLETED

G

03/06/2012

NAME OF PROVIDER OR SUPPLIER

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KNOXVILLE, TN 37919

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
TAG

F 309

Continued From page 19

Cardiac Dysrhythmia with Pacemaker Implant, Atrial Fibrillation, Chronic Anticoagulant Therapy, Hypertension, Hyperlipidemia, Anemia, Chronic Obstructive Pulmonary Disease, Depression, and Chronic Pain.

Medical record review of the Minimum Data Set, dated October 14, 2011, revealed the resident was rarely able to understand others; was sometimes able to make self understood; had short and long term memory deficits; had severely impaired decision making skills; required two person assistance for bed mobility and transfers; was non-ambulatory; required two person assistance for all activities of daily living; and was incontinent of bowel and bladder.

Medical record review of the results from the cardiac pacemaker monitoring company, dated May 26, 2011 and August 25, 2011, revealed "...Pacemaker: Medtronic, Inc. VERSA VEDR01 (specific type of device implanted)...Implant date: February 5, 2010...Diagnosis: SSS (Sick Sinus Syndrome - a malfunction of the heart's primary pacemaker causing an abnormal heart rhythm)..."

Medical record review of the recapitulation Physician Orders, dated October 1 - 31, 2011, revealed the resident was initially ordered to be a "DNR" (Do Not Resuscitate) on January 17, 2011 and the order was to be continued.

Medical record review of the Medication Administration Record, dated October 1 - 31, 2011, revealed the resident was identified as DNR status.

Medical record review of the Physician's Order,

F 309

What measures will be put into place or what systemic changes that will be put into place to ensure the deficient practice does not recur?

A master list of all residents who have a pacemaker will be maintained and updated by a QI Nurse. This list will be utilized to ensure pacemaker checks are scheduled and monitored as to presence of order, frequency of check, care plan update, and presence of any advance directive. The pacemaker check log will be reviewed every Friday by the DON for complete documentation. All Physician orders for residents are reviewed and documented by the primary nurse on a daily basis. This procedure is reviewed by chart audit weekly sample (10% of current charts) by the QI Nurse. MDS coord. will address all advance directives and comfort care orders in all resident care plans.

How the corrective action will be monitored to ensure the deficient practice will not recur. What quality program will be put into place?

Pacemaker checks/physician orders are monitored by the DON on a weekly basis (every Friday) and reported to the QI Nurse weekly for 6 months. Any variance in practice will be immediately investigated by the DON. All other physician orders will be reported through the QI Nurse's audit on a weekly basis for six months. The QI committee will review all findings to determine continued frequency of report. The QI team consist of Medical Director, Administrator, Pharmacist, Rehab Director, MDS Coordinators, Activity Director, Dietary Director, Medical Records, Social Workers Housekeeping and Maintenance Supervisor.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  BRAKEBILL NURSING HOME INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	<p>Continued From page 20</p> <p>dated October 18, 2011, no time noted, revealed "...have POA (Power of Attorney) sign Advance Directive (POST - Physician's Order for Scope of Treatment) for CMO (Comfort Measures Only)..."</p> <p>Medical record review of the Physician's Order, dated October 19, 2011, no time noted, revealed "...Make pt (patient) CMO DNR...no labs, no x-rays, no IV's (intravenous fluids), no antibiotics, no TF (tube feeding)..."</p> <p>Medical record review of the Plan of Care, updated October 14, 2011, revealed no documentation of identification of or interventions to be implemented for the care of the resident related to the resident's Cardiac Pacemaker, Do Not Resuscitate order, or the Comfort Care only order.</p> <p>Medical record review of the Clinical Record Nurse's Notes revealed the following sequential notes: October 22, 2011, at 2:30 a.m. - "...resting comfortable..."; October 23, 2011, at 4:00 a.m. - "...resting...periods of apnea (not breathing for brief periods)...comfortable..."; October 23, 2011, 3:00 p.m. to 11:00 p.m. (shift) - "...resting quietly...periods of apnea noted..."; October 24, 2011, at 2:30 a.m. - "...resting...periods of apnea noted..."; October 27, 2011, at 1:40 p.m. - "Resident c/ (with) no respirations or pulse. Pronounced death"; October 27, 2011, 7:00 a.m. to 3:00 p.m. (shift) - "Deactivated (questionable spelling) Pacemaker" signed by Licensed Practical Nurse (LPN) #1; October 27, 2011, at 2:00 p.m. - "(named) funeral home here to transport body to funeral home."</p> <p>Review of facility Incident Report for Resident #5,</p>	F 309			

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F 309	<p>Continued From page 21</p> <p>dated January 16, 2012, no time noted, signed by the Assistant Administrator, revealed "...CNA (Certified Nursing Assistant) #1 entered nursing office had several complaints about LPN #1. Questioning why a magnet was placed on Resident #5's chest on the day (resident #5) died...noted CNA #1 did not work on the day of (resident #5's) death October 27, 2011...(CNA #1) discussed all complaints with (named) Administrator and (named) DON (Director of Nursing)..."</p> <p>Review of facility Incident Report for Resident #5, dated February 13, 2012, at 1:00 p.m., signed by the Director of Nursing, revealed " (named) TBI (Tennessee Bureau of Investigation) at facility...investigating the death of (resident #5). Requested (resident #5's) entire medical record and access to any staff requested. Request honored...Administrator present..."</p> <p>Interview by phone with CNA #2 on February 29, 2012, at 8:25 p.m., confirmed on October 27, 2011, around lunchtime, CNA #2 was cleaning resident #5 along with CNA #3 and #4 and observed "a doughnut shaped red plastic covered" device on the chest of resident #5. Continued interview confirmed the resident was alive and breathing at the time. Continued interview revealed CNA #2 asked LPN #1 what the device was and was told to "leave it alone". Continued interview confirmed the CNA had never seen the device before. Continued interview revealed the CNA was talking about the observation sometime around Christmas and was told by CNA #1 that the device was a magnet and was not to be used on a dying pacemaker patient. CNA #1 reported the incident to Administration on</p>	F 309			

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NAME OF PROVIDER OR SUPPLIER

BRAKEBILL NURSING HOME INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

5837 LYONS VIEW PIKE  
KNOXVILLE, TN 37919

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F 309	<p>Continued From page 22 January 16, 2012.</p> <p>Interview by phone with CNA #3 on March 3, 2012, at 10:10 a.m., confirmed CNA #3 was helping clean resident #5 on October 27, 2011 and observed what looked like "a roll of red and white tape on the left side of the chest" of resident #5. Continued interview confirmed the resident was breathing at the time. Continued interview confirmed when LPN #1 was asked about the device the LPN told CNA #3 "It's a magnet. Leave it alone". Continued interview confirmed CNA #3 stated sometime around Christmas 2011 CNA #1 overheard CNA #3 talking about the incident and told CNA #3 a magnet was not to be used with a pacemaker.</p> <p>Interview by phone with CNA #4 on March 3, 2012, at 10:40 a.m., confirmed CNA #4 was helping clean resident #5 on October 27, 2011, around 10:00 a.m., and observed what "looked like a rolled up white tape on the left side of the chest" of resident #5. Continued interview revealed the resident was breathing. Continued interview confirmed the device was in contact with the skin of the resident and visible between the collarbone and breast area.</p> <p>Interview by phone with the Assistant Administrator on March 2, 2012, at 3:30 p.m., and review of an undated written statement, dated as received by the facility on March 7, 2012 and signed by the Assistant Administrator of January 16, 2012, regarding the Assistant Administrator presence for the events of January 16, 2012 and February 13, 2012, confirmed the Assistant Administrator was not informed of the exact nature of the incident reported on January 16,</p>	F 309		

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

445114

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

C

03/06/2012

NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

5837 LYONS VIEW PIKE

KNOXVILLE, TN 37919

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
TAG

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

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Continued From page 23  
2012; but was present while TBI interviewed LPN #1 on February 13, 2012. Continued interview revealed LPN #1 informed TBI about placing a magnet on resident #5's chest to deactivate the pacemaker when resident #5 was still living.

Interview in the Activity Therapy room with the Medical Director, who was the resident's attending physician, on February 29, 2012, at 11:30 a.m., revealed the Medical Director had no knowledge of the allegation of LPN #1 placing a magnet on the chest of resident #5 on October 27, 2011 until February 13, 2012 when the TBI completed a phone interview with the Medical Director. Continued interview confirmed no Physician's order was written to utilize a magnet on resident #5 for any reason other than pacemaker monitoring as directed by the company performing the readings on the specified dates by the company. Continued interview confirmed there was no reason for a magnet to be in the room or on the chest of any resident with a pacemaker.

Interview on March 5, 2012, at 3:30 p.m., in the Administrator's office with the Administrator confirmed LPN #1 placed a magnet on the chest of resident #5 who had a pacemaker and was alive at the time the magnet was placed on the resident's chest on October 27, 2011; and the facility had not developed and implemented policies for Cardiac Pacemakers or Comfort Measures Only prior to March 2, 2012.

The Immediate Jeopardy was effective from January 16, 2012 through March 2, 2012. A written Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy,

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F 309	<p>Continued From page 24</p> <p>was received on March 6, 2012 and corrective actions were validated as having been completed on March 2, 2012 through review of the facility documents and staff interviews conducted on-site on March 6, 2012. The verification of the allegation of compliance was confirmed by:</p> <p>1.) Reviewing the facility's revised policy for Abuse Prevention/Reporting Investigation to include more comprehensive information related to identification, preventing occurrences, reporting, investigating, protecting, and procedures.</p> <p>2.) Reviewing the facility's new policy and inservice records for Pacemaker Checks procedure.</p> <p>3.) Reviewing the facility's new policy and inservice records for the new Pacemaker/Defibrillator procedure.</p> <p>4.) Conducted interviews with CNA's and LPN's on all units, Housekeeping staff on all units, and Activity staff to ensure all had received inservices on Abuse Prevention/Reporting investigation and were able to identify types of abuse and when and how to report. Reviewing of the facility's inservice records on abuse, dated March 1 -2, 2012, to ensure all staff were inserviced prior to returning to work. Review of the facility plan for staff to be inserviced on abuse prior to returning to work if staff had not attended the abuse inservices.</p> <p>5.) Reviewed an additional six medical records for residents with pacemakers.</p>	F 309			

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F 309	Continued From page 25 6.) Reviewed an additional six medical records for residents on Comfort Only Care.  7.) Reviewed an additional three medical records of incidents of suspected abuse reported since March 2, 2012 to ensure the facility was following the procedures for reporting and investigating.  Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a plan of correction.  C/O #29340	F 309			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of literature of pacemaker devices, review of facility documents, and interview, the facility failed to be administered in a manner to protect residents from abuse, ensure abuse does not reoccur, and to ensure services rendered were according to physician orders for one resident (#5) of sixteen residents reviewed for abuse.  The facility's failure caused or was likely to cause serious harm, injury, impairment or death to resident #5.	F 490	F490 SS=J  What corrective action will be accomplished for the resident found to have been affected by the deficient practice, that facility failed to administer in a timely manner to protect resident from abuse and ensure abuse does not recur? Facility's failure was likely to have caused harm, injury, impairment or Death.  Unable to do immediate corrective action as resident had expired on 10/27/11.		3/15/12
			No pg 27.28 - 3/27/12 7:45 AM - called Norma Lindsay - she will fax immediately - mad.		

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F 490	<p>Continued From page 26</p> <p>The Administrator, Director of Nursing, and Unit Manager were informed of the Immediate Jeopardy in the office of the Administrator on March 5, 2012, at 2:15 p.m.</p> <p>The findings included:</p> <p>Interview in the Activity Therapy room with the Medical Director, who was the resident's attending physician, on February 29, 2012, at 11:30 a.m., revealed the Medical Director had no knowledge of the allegation of LPN #1 placing a magnet on the chest of resident #5 on October 27, 2011 until February 13, 2012 when the TBI completed a phone interview with the Medical Director.</p> <p>Interview with the Director of Nursing (DON) in the Activity Therapy room on March 5, 2012, at 10:10 a.m., confirmed the alleged perpetrator Licensed Practical Nurse (LPN #1) was not immediately suspended on January 13, 2012 while the facility conducted an investigation into the allegation of abuse of LPN #1 placing a magnet on the chest of resident #5 who had an implanted cardiac pacemaker while resident #5 was alive. Continued interview confirmed LPN #1 was not suspended until January 16, 2012. Review of the facility Time and Attendance Records for February 2012 revealed LPN #1 worked on February 24, 27, and 28, 2012 (for a total of 3 days). Continued interview confirmed LPN #1 was allowed to return to the facility on February 24 to work in the facility for non-resident care duties and was not terminated until February 28, 2012. Continued interview revealed the facility had not completed a full investigation until</p>	F 490	<p>How the facility will identify other residents having the potential to be affected by the deficient practice.</p> <p><i>All residents with pacemakers have the potential to be affected by abuse. All staff were Inservice on revised abuse policy of reporting, preventing and investigating. Abuse policy was revised on 2/29/12 by Administrator and DON and approved by Medical Director. New policy was developed on pacemaker checking by DON and Medical Director on 3/13/12. Documentation of education policy was done by the Don/Unit Managers on 3/13/12. Competency will be verified as pacemaker checks are scheduled. Abuse Inservice was done on 2/29/12 thru 3/2/12 (see attached revised policy on pacemaker checks completed on 3/13/12). Education included need to validate Physician order for any patient Intervention.</i></p> <p>What measures will be put into place to ensure the deficient practice does no recur?</p> <p><i>Facility now has in place policy on checking and documenting checks of pacemakers. Facility has policy on reporting, preventing and investigating any allegation of abuse. The DON and Unit Coordinators, after completing Incident investigation will determine need for reporting to State. The Supervisor or DON will immediately suspend the employee/person that abuse is alleged against, pending investigation.</i></p>		

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F 490	<p>Continued From page 27 March 1, 2012.</p> <p>Interview on March 5, 2012, at 3:30 p.m., in the Administrator's office with the Administrator confirmed the facility failed to immediately suspend the accused perpetrator; failed to complete a timely investigation of abuse that had been reported on January 16, 2012; failed to ensure a policy for pacemakers; and failed to report the allegation of abuse made on January 16, 2012 to the State.</p> <p>Refer to F-223 Refer to F-226 Refer to F-309</p> <p>The Immediate Jeopardy was effective from January 16, 2012 through March 2, 2012. A written Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received on March 6, 2012 and corrective actions were validated as having been completed on March 2, 2012 through review of the facility documents and staff interviews conducted on-site on March 6, 2012. The verification of the allegation of compliance was confirmed by:</p> <p>1.) Reviewing the facility's revised policy for Abuse Prevention/Reporting Investigation to include more comprehensive information related to identification, preventing occurrences, reporting, investigating, protecting, and procedures.</p> <p>2.) Reviewing the facility's new policy and inservice records for Pacemaker Checks procedure.</p>	F 490	<p>How the corrective action will be monitored to ensure that the deficient practice will not recur?</p> <p><i>Nurse will be checked for competency on checking pacemakers quarterly by DON or her designated Unit Coordinators. Staff will be inserviced quarterly and PRN on reporting, prevention and investigation of abuse. DON or Unit Coordinators will report in QI Quarterly times four, number type of abuse allegations and what was done to resolve each case, to identify trends, patterns and educational needs.</i></p> <p><i>Pacemaker/Physician orders are monitored by the DON on a weekly basis (every Friday) and reported to the QI Nurse weekly for 6 months. Any variances in practice will be immediately investigated by the DON. All other physician orders will be reported through the QI Nurse's Audit on a weekly basis for six months. The QI Committee will review all findings to determine continued frequency of report. QI Team consists of Medical Director, Administrator, Pharmacist, DON, Unit Coordinator, MDS Coordinator, Rehab Manager, Activity Director, Dietary Manager, Housekeeping, Maintenance Supervisors and Medical Records.</i></p> <p><i>This plan of correction is submitted as required under State and Federal Law and does not constitute an admission on the part of the Facility that the findings cited are accurate, or that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies were cited correctly applied.</i></p>		

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F 490	<p>Continued From page 28</p> <p>3.) Reviewing the facility's new policy and inservice records for the new Pacemaker/Defibrillator procedure.</p> <p>4.) Conducted interviews with CNA's and LPN's on all units, Housekeeping staff on all units, and Activity staff to ensure all had received inservices on Abuse Prevention/Reporting investigation and were able to identify types of abuse and when and how to report. Reviewing of the facility's inservice records on abuse, dated March 1 -2, 2012, to ensure all staff were inserviced prior to returning to work. Review of the facility plan for staff to be inserviced on abuse prior to returning to work if staff had not attended the abuse inservices.</p> <p>5.) Reviewed an additional six medical records for residents with pacemakers.</p> <p>6.) Reviewed an additional six medical records for residents on Comfort Only Care.</p> <p>7.) Reviewed an additional three medical records of incidents of suspected abuse reported since March 2, 2012 to ensure the facility was following the procedures for reporting and investigating.</p> <p>Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a plan of correction.</p> <p>C/O #29340</p>	F 490	<p>Added to Plan of Correction with permission of Adm. Norma Lindsey</p> <p>3/27/12 8:40 AM Mary Ann Sykes RN</p> <p>The Administrator will oversee to ensure all corrective actions are completed. The Medical Director will assist and consult with any Standards of Care and will oversee to ensure corrections are completed. The Medical Director will ensure Quality Assurance Committee involvement and monitoring of corrections.</p>		